

# Evaluation and Management Auditing

## WHITE PAPER



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### • Ensure appropriate coding and reimbursement for your practice

**E**valuation and management (E/M) codes describe the complexity of the professional services that a provider renders during a visit. These codes represent office, hospital, and nursing home visits, as well as consultations and other nonprocedural services. You can locate the codes in your CPT manual.

There are currently two sets of E/M coding guidelines published jointly by CMS and the AMA:

- 1995 Documentation Guidelines for Evaluation and Management Services
- 1997 Documentation Guidelines for Evaluation and Management Services

**Note:** You may view both sets of guidelines on the CMS Web site at [www.cms.hhs.gov/mlnedwebguide/25\\_emdoc.asp](http://www.cms.hhs.gov/mlnedwebguide/25_emdoc.asp).

When considering these guidelines, note that the two major differences between the 1995 and 1997 guidelines are in how you code the history of the present illness and the exam elements.

CMS allows providers to use either set of guidelines depending on which is the most advantageous to the provider. However, providers cannot mix and match the guidelines to support a particular level of service.

Some local state carriers have further requirements for E/M services, so check with your state's Medicare carrier for more information. For example, in May 2008, Trailblazer Health Enterprises, LLC, published guidance outlining a different requirement for review of systems documentation. According to official CMS and AMA guidelines, a provider must document only systems with positive or pertinent negative responses, and it is permissible for the physician to document a simple notation indicating all other systems are negative. However, Trailblazer has a specific requirement that differs from this national standard: "When using 'negative' notation, always identify which systems were queried and found to be 'negative.' " In other words, a notation stating that "all other systems are negative" is insufficient.

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## E/M auditing

Whether a practice is small or large, E/M coding is an integral part of the revenue cycle. In 2002, CMS allowed approximately \$18 billion per year for payment of E/M services. In 2004, that allotment increased to \$29 billion.

In 2007, there was a \$32 billion allotment. This represents a large portion of the Medicare budget and makes it clear why a practice should perform ongoing auditing and monitoring of E/M services.

It is best practice to perform audits of E/M coding for the following reasons:

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- Providers often unintentionally code incorrectly due to the complexity of assigning a code
- Providers often inappropriately assign E/M levels because they don't understand which elements of the documentation support an E/M level
- E/M audits help identify areas of opportunity for increased revenue, as well as ways to reduce compliance risks
- CMS has stated that providers have a responsibility to know the rules and regulations that apply to all services billed to Medicare

There are two ways to approach E/M auditing: prospective or retrospective. Both have their advantages and disadvantages. Prospective auditing occurs prior to when a claim is generated, allowing easy changes in the event that an auditor discovers an error. Retrospective auditing occurs after a provider bills a claim to a third party or carrier.

There are several advantages to performing a prebill/prospective audit. For example, this type of audit allows an auditor to:

- Identify coding errors that can lead to false claims
- Take proactive action
- Avoid refunds
- Educate billing providers and correct claims up front

However, a prospective audit does not indicate the financial effect of incorrect claims, nor does it detect whether a practice's billing system correctly maps the correct codes.

A postbill/retrospective audit allows an auditor to detect mistakes more easily and include educational opportunities in the audit scope not only for the billing providers, but also for other support staff members.

However, a retrospective audit permits an auditor to identify errors that could mandate a monetary refund. This type of audit also has the potential to lose its educational value, especially when you audit old claims. If the claim is too old, a practice may not be able to resubmit it for payment. For example,

when an auditor discovers undercoding or unbilled services, the claim may be past the allowed date to resubmit for payment.

When performing a retrospective audit, anticipate overpayments. Establish a written procedure on how the practice will handle/document overpayments found during the audit process.

Regardless of whether you audit prospectively or retrospectively, you should have strong policies and procedures to document auditing. Policies should cover:

- The scope of the audit
- Audit procedures
- Audit processes
- Action for audit findings
- A follow-up audit process

### Common E/M coding risk areas

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● The OIG has increased its auditing efforts regarding E/M coding, and, therefore, so should your organization. The OIG has found a significant error rate, which has resulted in overpayment of funds to physician practices.

Auditors are likely to focus efforts on high-risk areas. Areas the OIG has identified as high risk include the following:

- **Unbundling (i.e., separately billing for each component of a service instead of billing for all services using an all-inclusive code).** For example, a coder or physician reports 60 minutes of critical care using code 99291 and gastric intubation with code 91105. This would be incorrect because the gastric intubation code is included in reporting of the critical care service. Unbundling occurs most frequently when a coder is unaware of what is included in a procedure. When in doubt, coders should refer to the National Correct Coding Initiative (NCCI) edit list, which lists all-inclusive codes. NCCI edits are updated quarterly and are used to process claims and determine appropriate payments to providers. To view the physician NCCI edits, visit [www.cms.hhs.gov/nationalcorrectcodinitiated/NCCIEP/list.asp](http://www.cms.hhs.gov/nationalcorrectcodinitiated/NCCIEP/list.asp).
- **Clustering.** For example, a provider consistently bills all patients at levels three and four, assuming that all the codes will average out in the end. As a result, the provider overcharges some patients and undercharges others. This is a compliance risk and may cost the provider money by undercharging patients whom the provider should have billed at a higher level or even as a consultation.
- **Upcoding the level of service provided.** For example, a provider consistently bills all diabetic patients at a level five. As the only provider in the practice who sees diabetic patients, the provider feels that these are the most difficult patients to manage. The provider's documentation does not support a level five on any of the patients. This is a compliance risk and may also flag an

audit because the provider could be an outlier due to the number of level fives billed compared to peers in the same specialty or location.

Some specific E/M errors—many of which are the most common ones an auditor may encounter—include overcoding the following services without providing the required documentation:

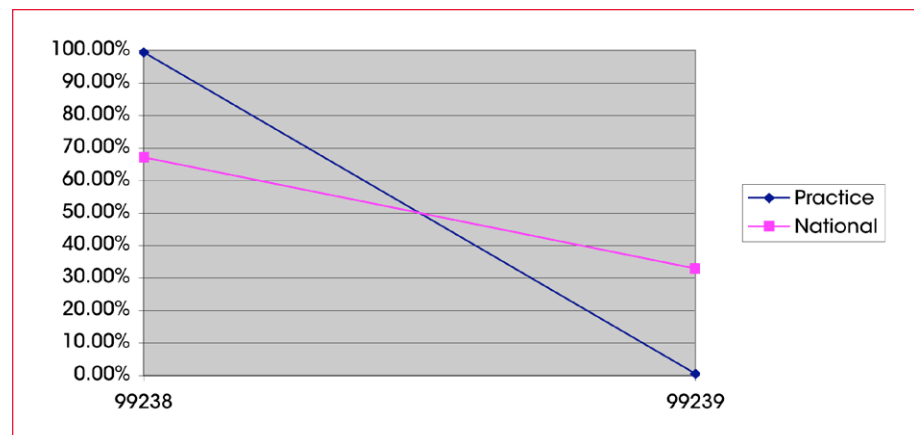
- Codes 99214, 99215 (office/outpatient visit, established patient)
- Codes 99203, 99204, 99205 (office/outpatient visit, new patient)
- Codes 99244, 99245 (office consultation)
- Codes 99221, 99223 (hospital admission)
- Codes 99291, 99292 (critical care services)

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- An auditor may also discover that a practice loses money because it undercodes certain services that a coder or physician could have coded at a higher level based on documentation. The following are typical examples of undercoding:

- Codes 99211, 99212, 99213 (office/outpatient visit, established patient)
- Codes 99241, 99242 (office consultation)
- Codes 99238, 99239 (hospital discharge day management)

To illustrate the common underreporting of codes 99238 and codes 99239, consider the following graph, which suggests that there is undercoding or underdocumentation occurring.



In this case, education on the documentation rules for assigning code 99239 is necessary for physicians and coders. Findings such as this can have a significant unfavorable effect on revenue. In addition, if a practice monitors work relative value units per visit, underdocumenting and undercoding would directly affect productivity data.

Keep in mind that undercoding often occurs because providers are uncomfortable billing higher levels of service for fear of becoming an outlier and ending up as a target of a regulatory agency's audit.

In general, when chart documentation is insufficient to support billed codes, there is an increased risk of government or commercial payer audit. This could result in significant financial loss.

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● In addition, be aware of potential issues if your clinical staff members use templates to document services. Audit templates can be helpful, and CMS does not oppose their use; however, proceed with caution. It is possible to sufficiently customize templates to a patient's complaint, thus creating a document with pertinent systems reviewed and even custom procedure notes that are check mark-based with some open fields for free text. This can be helpful to ensure optimal documentation for the encounter and assist with coding and charge capture.

However, the risk of using templates is that, often, the physician documents all of the necessary items to support the level of service billed, but doing so may not indicate that services rendered for the presenting problem were medically necessary during the visit. Some templates are very comprehensive, and a physician may be able to always complete every section to support a 99214 or 99215 office visit.

But the question of whether the services provided were medically necessary for the presenting problem should be asked. For example, a patient presents with a cough that he has had for the past few days. He has no past medical history and is otherwise a healthy patient. The patient's chest is not x-rayed, and his lungs sound clear. The physician's diagnosis is a cough. The physician subsequently documents the encounter on a template. Simply because the physician checks all of the boxes or leaves comments in all of the available spaces in the template doesn't mean it is appropriate to bill for a higher level E/M service when a lower service is otherwise warranted for the encounter.

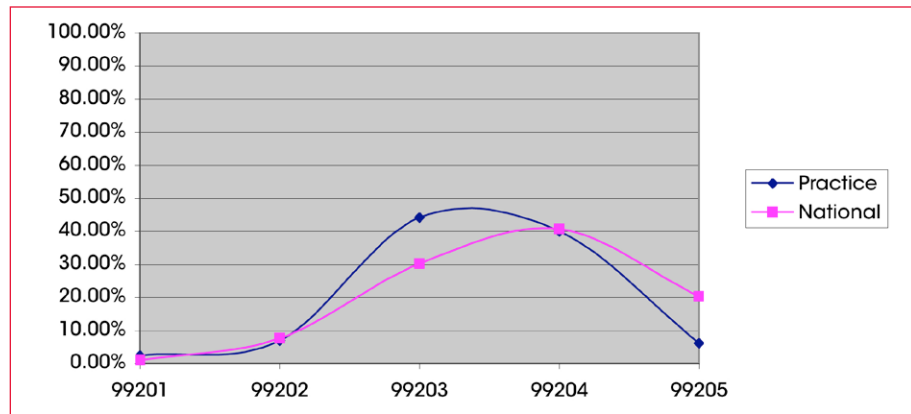
### Audit findings

Performing audits will allow you to monitor whether your organization's use of E/M codes falls reasonably near to national averages. Regardless of whether you have qualified physicians or trained coders reporting your E/M codes, you should profile your internal billing with an annual review.

Compare your E/M bell curve performance to national averages to determine whether you are an outlier due to under- or overcoding. You may find that you have left money on the table in certain instances.

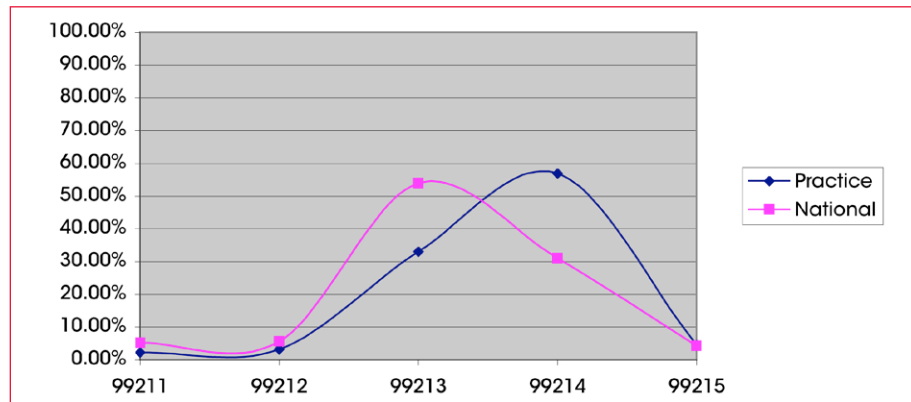
Consider the following examples of bell curves.

In the first graph, you see one practice's use of codes 99201–99205 reporting new patient office visits. It becomes clear that the practice may be overusing code 99203, but underreporting code 99205. The practice may, in fact, be leaving money on the table due to the latter.

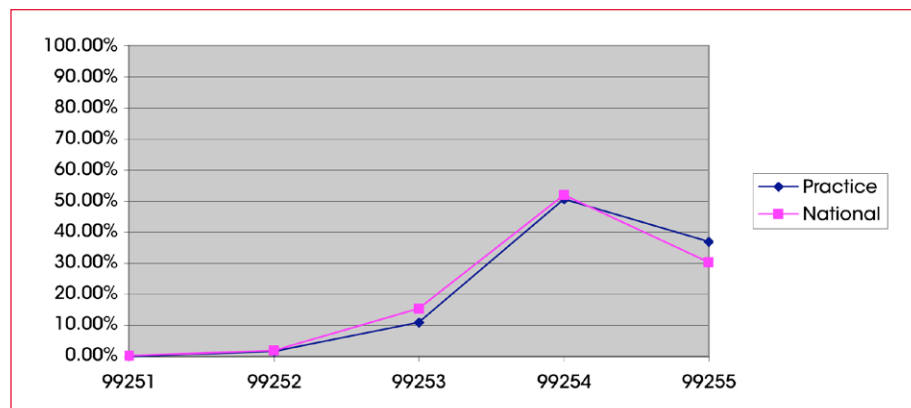


Keep in mind that simply because an E/M bell curve might suggest overcoding, that doesn't mean you must validate it by conducting an audit of the services.

The second E/M bell curve analysis of codes 99211–99215 reporting office visits by established patients suggests that this practice might be overcoding some of the services. Keep in mind that simply because an E/M bell curve might suggest overcoding, that doesn't mean you must validate it by conducting an audit of the services. The practice in this example should specifically review code 99214.



In this final E/M bell curve analysis, we see solid E/M code use when comparing the practice's performance to the national distribution for inpatient consultations (codes 99251–99255). There is nothing concerning about this graph. The practice should continue routine auditing and monitoring of services to ensure proper documentation to support the services billed.



When examining your organization's bell curves, be sure to ask the following questions:

- How do we compare with national averages?
- Do we have any lost revenue?
- Can we identify any potential compliance risks due to over- or undercoding?

Taking the time to answer these questions will ensure that your audits are effective—you may identify potential revenue your practice would have otherwise missed, and you will identify places where you may be at risk.

Although the focus for auditing and monitoring is certainly compliance, increased revenue is often a byproduct.

- Performing E/M audits on a routine basis is considered best practice. Auditing and monitoring services should be part of the fabric of any practice or healthcare provider. Considering regular audits to be optional or only conducting audits when a concern arises is risky and can come with a huge price. In addition, audits should expand beyond E/M codes to look at all services charged to ensure optimal documentation and claim submission. Although the focus for auditing and monitoring is certainly compliance, increased revenue is often a byproduct. If a practice does not perform routine audits, it could easily miss significant revenue opportunities.

Also, don't become too comfortable and forgo auditing when your practice or organization meets or exceeds its financial goals. A practice can always be at compliance risk for overcoding, undercoding, and/or unbundling services. And although a practice might be meeting financial goals, it could still be missing revenue opportunities if it doesn't regularly conduct audits. ■

*Editor's note: Rivet is a regulatory specialist with HCPro's Revenue Cycle Institute and instructor for the Evaluation and Management Boot Camp®. He is coauthor of the book Auditing Evaluation and Management Coding. For more information on HCPro Boot Camps, including Certified Coder Boot Camps® and our newest offering, Evaluation and Management Coding and Auditing Boot Camp®, visit [www.hcprobootcamps.com](http://www.hcprobootcamps.com).*



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